STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953614	**08/15/2017**
NAME OF PROVIDER OR SUPPLIER **GREEN ACRES**	STREET ADDRESS, CITY, STATE, ZIP CODE **15820 ARCHER STREET** **HUDSON, FL 34667**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

Assisted Living Facility

A complaint investigation, (CCR# 2017006117), was conducted from - at Green Acres, (Lic. #8642). Green Acres had deficiencies identified at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview the facility failed to provide personal supervision and care and services, sufficient to meet the needs of their residents. Specifically, the facility failed to seek medical attention, provide , , ( ) when a resident was unresponsive and not breathing, failed to maintain a general awareness of the well-being of the resident and failed to contact the case manager or family when the resident exhibited a significant change for one of seven sampled residents (Resident #1.) Resident #1's change in physical condition and behavior was not documented or reported and facility staff did not initiate when Resident #1 became unresponsive. As a result, Resident #1 .

Findings included:

A review of Resident #1's resident record conducted on revealed a note written by Staff A regarding Resident #1's activities and behavior on . The note from Staff A recapping the events of did not include documentation of any notification to a licensed physician or health care provider following a change in Resident #1's condition. On , according to the note from Staff A in Resident #1's record, Resident #1 exhibited a change in behavior (self-injurious.) Resident #1 was observed by Staff #A and other residents banging their head into a washing machine, on a marble step in the shower stall and on walls of the facility. Additionally Resident #1 was observed throwing themselves onto the floor. During an interview with Resident #8 on at 10:15 AM, Staff #A was aware of noises and was told by Resident #8 that Resident #1 was throwing themselves onto the floor and was banging their head into the wall in the facility hallway. Staff #A did not respond to the noises or intervene after Resident 8's notification of Resident #1's behavior. Staff #A did not contact Resident #1's case manager, health care provider or family to notify them of any change in behavior.

Although in an interview with Staff #A on at 12:27 PM, Staff #A stated Resident #1 exhibited, self-injurious behavior by banging their head into walls approximately 2-3 times a week for the past 2

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months, Resident #1's record did not include any documentation of self-injurious behavior since admission to the facility nor any documentation of notification to the case manager, health care provider or family.

An interview was conducted with Staff #A on at 12:27 PM. Staff #A stated at breakfast Resident #1 stated, "I am going to die today." According to Staff A, Resident # 1 then proceeded to lock themselves in the . Staff #A stated when they got into the , they witnessed Resident #1 banging their head on the washing machine and the marble step of the shower stall. Staff #A stated there were visible on Resident #1's head but no . Staff #A stated they called the Administrator and explained Resident #1's behavior and the Administrator stated, "Don't call 911, she is crazy." According to Staff #A, after the phone call Resident #1 proceeded to throw themselves onto the dining and Staff #A then called 911. Staff #A stated the emergency medical services ( ) arrived and stated, "Oh it's her, she does this all of the time." They spoke to Resident #1, got them to calm down, put them in bed, told them to rest, and left the facility. At the time of survey, there was no documentation in Resident #1's record of the incident reflecting that had been at the facility for Resident #1's self-injurious behavior. Staff #A stated a few hours later, Staff A was in the staff they heard noises in the facility but did not respond to them. Staff #A stated Resident # 8 stated, "Resident #1 is banging their head into the hallway wall and throwing themselves into the floor." Staff #A stated she did not respond or intervene. Staff #A stated at dinner Resident #1 was stumbling in the dining and hit their head. Staff #A stated she got Resident #1 up, sat her in a chair in the main living area, and called a private ambulance transport, not 911. Staff #A stated before the arrival of the transport, Staff #A found Resident #1 was unresponsive with no pulse. Staff #A stated she then called 911. Staff #A stated, "I did not do ." "I called 911." Staff #A stated she did not know if Resident #1 had a ( ).

A review of the facility policies and procedures was conducted on . The policies and procedures states if a resident does not have a , the staff will initiate , ( ) to the resident.
An interview was conducted with Resident #1's case manager and licensed mental health counselor on at 2:33 PM. The Case Manager stated they visited Resident #1 once per week. The Case Manager stated they were not notified of any self-injurious behaviors since Resident #1's admission to the facility in 2017. They stated they were not notified of any changes of behavior. The Case Manager stated their nurse on call was notified on at 6:45 PM that the facility staff sent Resident #1 to the hospital. The nurse requested the facility get more information and call back. The Administrator notified the Case Manager on that Resident #1 had at the hospital during the night. The Case Manager was not provided any additional information regarding the circumstances or specifics of behaviors on the date of Resident #1's .

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On at 2:11 PM, an interview was conducted with an Emergency Medical Technician (EMT) from the private ambulance transport who was called to the facility on . The EMT stated their dispatch received a call stating a resident of the facility needed a evaluation because they were reportedly refusing their medications. The EMT stated when they pulled in the facility driveway someone was screaming, "She's not breathing." Once inside, the caregiver on duty (Staff #A) stated, "she's not breathing, no pulse." The EMT stated the patient (Resident #1) was slumped over in a chair and appeared unresponsive. The EMT tried to wake them up with a rub with no response. The EMT stated Resident #1 were unresponsive with no pulse. The EMT started and called their dispatch to request Emergency Medical Services ( ) back up. The EMT continued for approximately 10 minutes until backup arrived. The EMT stated the facility staff did not start or call 911.

An interview was conducted with the Administrator on at 1:31 PM. The Administrator stated, "Resident #1 was never depressed; they did hit their head sometimes." The Administrator further stated, "The staff have been trained on emergency procedures, and ."

Class I

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review and interview, the contracts of four of four residents whose records were sampled (#1; 2; 7; 9) contained verbiage that was in direct conflict with the Resident Bill of Rights found in statute, allowing the facility to require a resident to move out without the facility providing a 45-day notice.

Findings included:

A review of the residency agreements for Residents #1, 2, 7, and 9 all found a provision indicating the facility could issue the resident/their representative a notice of discharge for less than the standard 45 days regarding circumstances involving non-payment.

Interview with the administrator at 2:00pm on provided no clarification or explanation.

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Class III

0076 - ( ) - 58A-5.0186 FAC

Based on record review and interview the facility failed to follow their ( ) policies and procedures. The employee on duty in the facility providing care to the residents (Staff #A) did not initiate , , ( ) on a resident (#1) found unresponsive with no pulse.

Findings included:

On , Staff #A, who was the only staff on duty, found Resident #1 unresponsive with no pulse. Although Resident #1 did not have a , Staff #A did not initiate .

A review of the facility policies and procedures was conducted on . The policies and procedures states if a resident does not have a the staff will initiate , , , ( ) to the resident.

An interview was conducted with Staff #A, on at 12:27 PM. Staff #A stated, "I did not start ." "I called 911."
An interview was conducted with the Administrator on . The Administrator stated, "The staff have been trained on emergency procedures, and ."

Class II

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observation, interview and record review, two of four staff sampled (B; C) had no formal evaluation from a health care provider attesting to their freedom from communicable including ( ) conducted within the past 6 months, or had their status updated annually nor had documented evidence of completing any required training relevant to their duties.

Findings included:

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At 10am on , Staff B was noted to be working at the facility alone with all seven (7) residents on the premises. Interview with Staff B at this time revealed that "she worked for the administrator at least once a week to give her a chance to do errands, conduct business, etc., and that she had been doing this for several months." When asked when the administrator would return, the designee was not sure. This writer observed the staff member interact with residents, clean, and both prepare as well as serve, the noon meal throughout the morning. Upon the arrival of the administrator, this employee's file was requested, but according to the administrator, "since she thought Staff B was only a cleaning lady, no personnel record was maintained." Thus, no communicable statement including nor any training-related documentation pertaining to Staff B was available for inspection.

With respect to Staff C, a review of the latest evaluation found a document that had expired . Interview with the administrator at 11:45am on verified that this employee did not have a subsequent assessment.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on record review, interview and observation, the facility did not maintain sufficient staffing hours per week to meet the needs of its residents.

Findings included:

At 9:40am on , the administrator stated in an interview that she had seven (7) residents and that she was the only person working at the facility. Upon questioning if anyone else was working for her in , 2017, she replied that one (1) other individual was employed 36 hours/wk. With a census of seven (7), a review of the facility's current staffing schedule for the month of 2017 revealed that the facility short of the required 212 hrs./week.
In , 2017, the facility also had 7 residents, and therefore was short by 8 hours per week.
The administrator stated in an interview at 2:15pm on and at 12pm on that "it's difficult finding good staff!"

Class III

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0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on record review and interview, three of four current and former staff sampled (A; B; C) did not have documentation of current First Aid and ( ) certification available for agency review.

Findings included:

Personnel file review during an complaint investigation revealed that Staff A was hired .
Further record review indicated that this individual was working in the facility alone on the day of the event in question. However, no First Aid or certificate could be located.
In an Interview with the administrator at 1:20pm on , the admininstrator indicated that "the former staff member apparently took these two documents with her upon departing from the facility after leaving her employment."
With respect to Staff B, interview with this individual at 10:15am on revealed that she didn't have current First Aid and certification and couldn't produce any updated cards or documentation.
Upon request, the administrator was unable to produce any current First Aid/ training certification for Staff B, stating that "she thought this wasn't necessary for a cleaning/housekeeping person." Finally, according to the administrator and review of the revised staff schedule , Staff C apparently worked 12 hrs./day, 3 days/wk. A review of this person's personnel file found no First Aid/ certification.
Interview with the administrator on at 1:25 PM provided no clarification for this oversight.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview, the facility did not maintain a complete record of adverse incident reports with respect to one of one resident sampled (#1) who was involved in a reportable event.

Findings included:

Resident record review revealed a progress note describing Resident #1 "throwing him/herself to the ground repeatedly." This was further underscored by interviews with at least five (5) relatively alert and oriented residents who stated they had all witnessed the resident falling on . Furthermore, this

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episode ultimately led to the staff person in charge calling "911" and Resident #1 going out to the hospital. Interview with the administrator on at 2:25pm confirmed that she was notified by the hospital that Resident #1 had expired the following day, . Further review of the file found no documentation of any official incident report form--either the one (1) day or the fifteen (15) day, having been completed and sent to the Central office regarding the event in question. Interview with the administrator at 2:40pm on indicated that no adverse incident report form had been filled out because "she believed the resident had of a and since the resident had expired due to natural causes, no such form was necessary."

Class III

L241 - LMH - Records - 429.075(3-4); 58A-5.029(2) FAC

Based on record review and interview the facility failed to ensure 2 of 7 (#2 and #7) limited mental health resident records included a community living support plan and a agreement with a mental health care services provider or written evidence of a request for one.

Findings included:

A record review was conducted on of the resident record for Resident #2. Resident #2's record did not include a community living support plan or a agreement with a mental health care provider.

A record review was conducted on that same date of the resident record for Resident #7. Resident #7's record did not include a community living support plan or a agreement with a mental health care provider.

In review of Resident #2 and Resident #7's record's there was no documentation of communication between the Administrator and a mental health care provider in order to obtain mental health services as required.

An interview was conducted with the Administrator on at 2:35 pm. The Administrator stated, "I am trying to find case management for them."

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Class III